as Zimbabwe and be willing to act in the interests of solidarity, human rights, and peace? International professional groups should take up human rights issues at their global meetings, draw up resolutions, and use them to advocate for the rule of law in political arenas. Discussion at a WHO congress will carry more weight than complaints from potentially vulnerable national groups, especially in Zimbabwe, where there is a real risk of retaliation at home. Academic bodies in developed countries with bioethics expertise should use their knowledge and skills to collaborate with centres or individuals in developing countries. In this way, capacity to educate health professionals within Zimbabwe in ethical and legal issues will be enhanced. Non-governmental organisations and other philanthropic groups should support national groups seeking outside support. Without this help, the Zimbabwean medical community remain powerless in the face of ongoing human rights abuses.

Anonymous
The author is a practising physician in Zimbabwe; however, as a result of the Zimbabwean Public Order and Security Bill, which became law on Jan 23, 2002, the author's name cannot be disclosed.

1 International Rehabilitation Council for Torture Victims. Organised violence and torture in Zimbabwe. Copenhagen: IRCT, 2000 (www.irct.org/Zimreport.htm).
2 Johnson RW. *Sunday Times*, London: Jan 20, 2002.

Detention of asylum seekers in Australia

Detention is the most draconian punishment known to most liberal democratic societies. To incarcerate a person for an indefinite period when they have committed no crime is difficult to justify under any circumstances. Australia places many asylum seekers, most of whom have suffered past trauma, including torture, in open-ended terms of detention. Terms of 4 years or more are not uncommon. Children are not exempt from such treatment, whether or not accompanied by a family member. The health effects of detention have been previously documented (see *Lancet* 2001; **357:** 1436–37). In addition, recent reports[1] indicate that compromises are being made in the provision of ethical health care offered by the private company Australasian Correctional Management (ACM), which is responsible for the running of the detention centres in Australia on behalf of the federal government.

There have been continuing acts of self-injury, hunger strikes, and attempted suicide in Australia's six detention centres and similar tales in the newly established Australian-funded centres in Pacific countries of Papua New Guinea and Nauru. On more than one occasion in recent years, asylum seekers have sewn their lips together to draw attention to the hopelessness of their situation. In August, 2000, ACM used tear gas, and for the first time in Australian history, water cannons to quell a riot in one of the centres.[1]

A recent edition of the *Medical Journal of Australia* featured discussion on the health of asylum seekers. Of note was the impact of detention itself, compounding the psychological effects of earlier experience under inhumane regimes.[2] Detainees may be called by number not name, and are subject to line-ups, head counts, and room searches, often at night. Asylum seekers may be placed in solitary confinement. Detainees commonly lack meaningful activities. These conditions, characteristic of imprisonment, are hard to justify. Of particular concern are the effects on children. As A Sultan and K O'Sullivan note[2] "A wide range of psychological disturbances are commonly observed among children . . . At the most severe end of the spectrum, a number of children have displayed profound symptoms of psychological distress, including mutism, stereotypic behaviours, and refusal to eat or drink."

ACM is responsible for the provision of health care to detainees. Nurses work in the centres and general practitioners, who do not necessarily have relevant experience (see *Lancet* 2001; **359:** 683) are commonly contracted and seen by appointment. Consultations sometimes occur in the presence of guards. Access to medical care at times other than the contracted periods must be negotiated through staff. If official escorts are unavailable, appointments may be cancelled. Should a detainee require treatment outside a centre or admission to hospital, they may be handcuffed or otherwise restrained and accompanied by one or more guards. The Australian Medical Association has asserted that detainees are often deprived of basic medical care, particularly emergency care. It has argued that the government should provide temporary access to Australia's universal subsidised system of health care.

The Royal Australian and New Zealand College of Psychiatrists has been outspoken in raising the ethical concerns for medical practitioners working in the centres. Without calling for a ban on medical practitioners working for ACM, the college has stated that medical professionals need to seriously consider the ethical implications of accepting such positions given the inadequacy of health services available in the centres. Louise Newman, the Chair of the Faculty of Child and Adolescent Psychiatry told *The Lancet* "Medical practitioners face the dilemma of an intrinsic conflict between the desire to provide appropriate care, and the compromising of this by supporting a pathological system. This is similar to the issues that confronted doctors in Soviet Russia or Nazi Germany."

An incomplete version of the contract between ACM and the federal government for the running of immigration detention centres is publicly available (www.immi.gov.au/illegals/acs.htm). Medical officers are to monitor solitary confinement, and chemical restraints may be used only under medical or nursing supervision. In at least one instance, however, a general practitioner gave authority to an accompanying nurse to apply chemical restraint with haloperidol to avoid difficult behaviour by a family being forcibly deported.

The ACM contract for health-care professionals working at the centres states that the care needs of detainees are to be regularly monitored and they are to be provided with necessary care and reasonable dental treatment. Expectant mothers are to have access to antenatal and postnatal services. There is now substantial evidence to suggest that these contractual obligations have not been met. Yet it is difficult to ascertain what action is being taken by the government on these issues.

Australia must remain true to its traditions of welcoming people who have fled there fearing persecution in their original homeland. Despite mounting criticism, the Australian government continues to assert that it is not in breach of its international obligations to asylum seekers. But what of health-care personnel in their provision of care? In 1982 the UN General Assembly came to the

decision that "Health personnel, particularly physicians, charged with the medical care of prisoners and detainees have a duty to provide them with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained". This standard is not being uniformly upheld.

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1 Mares P. Borderline: Australia's treatment of refugees and asylum seekers. Sydney: University of New South Wales Press, 2001.

2 Sultan A, O'Sullivan K. Psychological disturbances in asylum seekers held in long term detention: a participant-observer account *Med J Aust* 2001; **175:** 593-96.

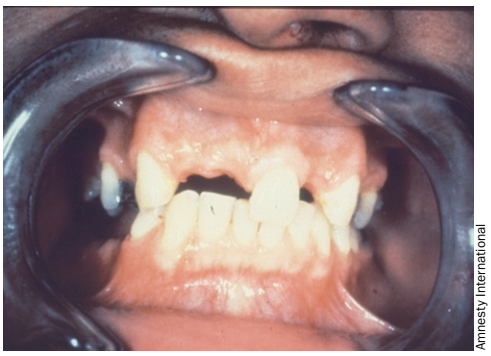
A body of evidence: torture among asylum seekers to the West

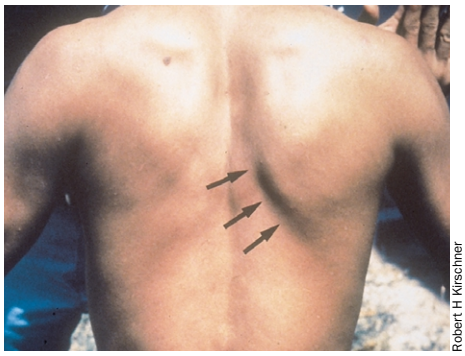
It is a depressing fact that despite universal condemnation of the use of torture, it is still practised systematically throughout more than half the world. Indeed, the last worldwide torture survey by Amnesty International (www.stoptorture.org) reports that cases have dramatically increased in recent years; most individuals, according to the survey, are women and children.

Victims of torture are often faced with no option but to flee their homes; some individuals will brave long and dangerous journeys in order to reach western shores to claim political asylum. All medical practitioners therefore need to be aware of the consequences of torture when they see an asylum seeker or a refugee for the first time. There may be obvious signs of physical torture, but most will be of mixed physical and psychological origin.[1]

Michael Peel from the Medical Foundation for the Care of Victims of Torture (London, UK), says that in excess of 5000 individuals each year are referred to his centre, the vast majority of whom will have had some degree of torture in their country of origin. "In most of the countries we see people from, the torture is relatively unsophisticated: punching, kicking, beating with batons, and other objects. Cigarette burns are surprisingly common, and electrical devices are used in a number of countries." Although in many African countries, particularly in West Africa, there is torture with impunity, Peel told *The Lancet* "in countries such as Turkey and India the authorities are careful not to leave scars . . . in Sri Lanka, for instance, the army uses a technique in which a plastic bag containing a small amount of petrol is wrapped around the victim's head—the smell of the petrol partially asphyxiating the victim, and making them feel sick and faint. A similar technique is used in Zimbabwe, but foul water is used in place of petrol".

Peel stresses that most medical concerns of asylum seekers and victims of torture are the same as anyone elses, and that ongoing care and support does not have to be provided by specialists. However, he adds "you can't do a proper assessment without a good quality interpreter. Taking a thorough testimony can be therapeutic, but it needs to be done in an encouraging environment and needs to have time dedicated to it".


Amnesty International


Robert H Kirschner

Left: Teeth have fallen out following direct trauma and electric-shock torture. Right: "Wing" scapula after prolonged suspension— a common form of torture, causing extreme pain but leaving little visible evidence of injury

A recent publication from Physicians for Human Rights[2] notes that medical practitioners are often reluctant to raise the question of torture among refugees and asylum seekers who present to the surgery, but that documenting this information is often crucial in enabling adjudicators to make accurate decisions on asylum claims. As a practical guide to issues relevant to torture in this group, the book offers advice for practitioners on assessing psychological and physical evidence of torture, and includes an overview of political asylum law and procedure in the USA. It is important to note, say the authors, that the absence of obvious physical evidence should not be construed to suggest that torture did not occur. Although acute lesions may be characteristic of the alleged injuries, most lesions heal within about 6 weeks of torture leaving no scars or non-specific scars. But says Peel, "A detailed account of the patient's observations of acute lesions and the subsequent healing process often represents an important source of evidence in corroborating specific allegations of torture or ill treatment". A chapter is devoted to the long-term manifestations of the many forms of physical torture, including suspension torture (figure), positional torture, blunt trauma, dental torture (figure), asphyxiation, and electric-shock torture.

Asylum seekers who have previously been tortured are of increasing concern to many medical professionals in countries like the USA, Australia, and the UK in light of a growing and worrying trend to detain asylum seekers in prison-like conditions on arrival, often for uncertain time-periods. A recent study of Tamil refugees[3] found that among those who had been tortured there were statistically significant higher scores for diagnosis of post-traumatic stress disorder than other war trauma survivors; mental health concerns that are certainly exacerbated by prolonged periods of detention. According to lead investigator, Derrick Silove, "detention poses a profound crisis not only for the mental health of those detained, but for any claims that the world's developed nations may have to providing leadership in the human rights field.